

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-012724

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 277 Primary Registration District No. 3949 Registrar's No. 15

FILED APR 3 1963

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Guivre Township</u>		c. CITY OR TOWN <u>Louisiana</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>8 MI NW Louisiana</u>		d. STREET ADDRESS (If outside, give location) <u>RFD # 2</u>	

3. NAME OF DECEASED (Type or print) First <u>Jonah</u> Middle <u>-</u> Last <u>Calhoun</u>			4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1963</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-83</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Butler Co., Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>US</u>		13a. FATHER'S NAME <u>John Braun</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Schluter</u>	
14. NAME OF HUSBAND OR WIFE <u>George W. Calhoun</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Ed Henson Bowling Green, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: <u>Pneumonia</u> DUE TO (b) <u>Influenza</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>3 days</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>11-7-61</u> to <u>3-24-63</u> and last saw her alive on <u>3-24-63</u> Death occurred at <u>10:00 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert A. Branks D.O.</u>		22b. ADDRESS <u>Bowling Green, Mo.</u>	
22c. DATE SIGNED <u>3-26-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>3-27-63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		23e. REGISTRAR'S SIGNATURE <u>Maidea E. Williams</u>	

24. FUNERAL DIRECTOR <u>J. O. Mudd</u>		25. DATE RECD. BY LOCAL REG. <u>March 26, 1963</u>		26. REGISTRAR'S SIGNATURE <u>Maidea E. Williams</u>	
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

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JUN 22 1968

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James O. Mudd

Licensed Embalmer No. 4152

P. O. Address Burlington, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.